PATIENT HEALTH QUESTIONNAIRE

NAME: First Middle Last _____

Today's Date _____

Date of Birth _____
Marital Status _____
Occupation _____

DRUG ALLERGIES OR REACTIONS _____

_____

Date of Last:

Last Menstrual Period _____
Mammogram _____
Pap Smear _____
DEXA Scan _____
Colonoscopy _____
Cologuard _____

MEDICAL HISTORY (List illness/surgery and dates)

CHRONIC ILLNESSES	
HOSPITALIZATION	
OR	
PREVIOUS MAJOR	
SURGERIES	

Please check if you have or have had the following:

☐ DIABETES ☐ HIGH BLOOD PRESSURE ☐ STROKE ☐ HEART DISEASE ☐ LUNG PROBLEMS
☐ BLOOD CLOTS ☐ SEIZURES ☐ DEPRESSION / ANXIETY ☐ CANCER. Type_____

FAMILY HISTORY	AGE IF LIVING	AGE AT DEATH	PRESENT CONDITION OR CAUSE OF DEATH
FATHER			
MOTHER			
BROTHERS			
NUMBER _____			
SISTERS			
NUMBER _____			
CHILDREN			
NUMBER _____			

HAS ANY RELATIVE HAD THE FOLLOWING:

☐ Alcoholism _____
☐ Alzheimer's _____
☐ Anemia/Low Blood Count _____
☐ Lung Problems _____
☐ Cancer, Breast _____
☐ Cancer, Colon _____
☐ Cancer, Prostate _____
☐ Cancer, Other _____
☐ Heart Disease _____
☐ Depression _____
☐ Bipolar Disorder _____
☐ Diabetes _____
☐ Blood Clots _____
☐ Hearing Loss _____
☐ High Blood Pressure _____
☐ High Cholesterol _____
☐ Osteoporosis _____
☐ Stroke _____
☐ Other _____

PLEASE LIST CURRENT PRESCRIPTION MEDICATIONS, OVER THE COUNTER MEDICATIONS, AND HERBAL SUPPLEMENTS:

_____
_____
_____
_____

Are you taking aspirin daily? ☐ Yes ☐ No Birth Control Method: _____
Do you have any objections to a blood transfusion? ☐ Yes ☐ No

Immunization Shots

Dates of Last: Flu_____ Tetanus_____ Pneumonia_____ Hep A _____ Hep B _____

SOCIAL HISTORY

EXERCISE:	SMOKING:	ALCOHOL:	RECREATIONAL DRUGS	Y	N
Type _____	Packs per day _____	Drinks per day _____		☐	☐
_____	No of years _____	Drinks per week _____			
_____	Year stopped _____				
How often? _____	☐ Pipe ☐ Cigar ☐ Chew	Alcohol problem: ☐ Yes ☐ No			

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PLEASE CHECK ALL THAT APPLY AND/OR WRITE IN OTHER PROBLEMS.

GENERAL HEALTH ☐ Fatigue ☐ Weakness ☐ Weight loss ☐ Ankle swelling ☐ Sleep problems
☐ No problems ☐ Other _____

MENTAL HEALTH ☐ Memory problems ☐ Depressed ☐ Tense, nervous
☐ No problems ☐ Other _____

BRAIN AND NERVES ☐ Fainting ☐ Poor balance ☐ One or more falls in past 6 months
☐ No problems ☐ Other _____

URINARY ☐ Leaking bladder ☐ Difficulty urinating ☐ Sexual difficulty or concern
☐ No problems ☐ Other _____

BONES AND MUSCLES ☐ Difficulty or pain with walking ☐ Painful joints
☐ No problems ☐ Other _____

HEAD AND NECK ☐ Hearing problem ☐ Eyesight problem
☐ No problems ☐ Other _____

BREATHING ☐ Cough ☐ Short of breath
☐ No problems ☐ Other _____

HEART ☐ Chest pain or pressure ☐ Irregular heart beat ☐ Leg pain with walking
☐ No problems ☐ Other _____

STOMACH AND BOWELS ☐ Swallowing trouble ☐ Indigestion ☐ Abdominal pain
☐ Constipation ☐ Diarrhea ☐ Blood in stool or black stools
☐ No problems ☐ Other _____

SKIN ☐ Rash ☐ Skin problems ☐ Skin cancer
☐ No problems ☐ Other _____

Other ☐ Gonorrhea ☐ Herpes ☐ Chlamydia

WOMEN ONLY ☐ Abnormal Vaginal bleeding ☐ Vaginal Discharge ☐ Abnormal pap
☐ Hot Flashes ☐ Breast lump ☐ Breast pain
☐ No problems ☐ Other _____

Patient/Family Member_____ Date_____

Please print patient name_____